Summer @ BB&N: Physician Health Form

***All** employees must provide documentation of an annual physical examination within the twelve months preceding the opening of camp.*
his form is to be completed by a Licensed Provider prior to attendance at camp. Please mail completed forms to Summer @ BB&N

Mail to: BB&N Summer Camp, Attn: Summer Camp Director, 80 Gerry's Landing Road, Cambridge, MA 02138

Employee's Name______________________________Date of Birth: _______________ Are you over 18yo?________

Physical Examination by a Licensed Provider: *The remainder of this form is to be completed by a Physician L*

I. Complete Health History

Check YES or NO if you have experienced any of the concerns listed. If YES, describe.

Health Concerns	Yes	No	Comments - Treatments and appropriate dates
Cardiac Disease			
Seizures/Neurological Disorder			
Diabetes/Metabolic Disorder			
Blood Disorder			
Hospitalizations/Surgery			
Asthma/Respiratory Disorder			
Chronic Illness			
Visual Deficit/Eye Disorder			
Hearing Deficit/Ear Disorder			
Speech Deficit/Throat Disorder			
Digestive Disorder/Diet Restriction			
Orthodedic Disoder/Activity Restriction			
Menstrual/Genitournary Disorder			
Chicken Pox			
Mononucleosis			
Psychological Concerns			
Attention Deficit Disorder			
Eating Disorders/Compulsions			
Suicide Gestures			
Other			

ALLERGY HISTORY

Do you have any allergies? (Circle one) YES NO

If "Yes," please document allergy, typical response and treatment plan.

ALLERGEN	Typical Reaction	Treatment Plan

VALIDATION OF HEALTH HISTORY and RELEASE CONSENT: I do hereby confirm that the health information provided here is accurate and honest. I give consent for information relevant to my safety to be released on a need-to-know basis.

Signature of Employee ____ Date ____________

If Employee is under 18 yo: Signature of Legal Guardian __________________________ Date ____________

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II. Physical Examination by a Licensed Provider

Please have the Licensed Provider complete this form or a form supplied by the Licensed Provider may be attached to this form.

I have examined____on _____________.

IMMUNIZATION HISTORY

Please record the dates (month/year) of basic immunizations and most recent booster.

VACCINES	Dates			
DPT				
Td				
OPV/IPV				
MMR				
Hib				
Hepatitis B				
PPD/Mantoux				
Varicella				
Other				

PHYSICAL EXAMINATION

Please indicate "YES" if individual's examination is *within normal limits* or "NO" if exam is of concern.
If "NO" is checked, please describe condition.

Height _____ Weight _____ Pulse ______ Respiration ________ Blood Pressure ______

SYSTEM	YES	NO	Comment
General Appearance			
Skin			
Eyes/Vision			
Ears/Hearing			
Nose			
Mouth/Teeth			
Cardiovascular			
Lungs			
Abdomen			
Genitourinary			
Musculoskeletal			
Neurologic			
Development			
Other			

RECOMMENDATIONS WHILE AT CAMP

- Does the individual have any activity restrictions? YES NO Describe ________________________
- Does the individual have any dietary restrictions? YES NO Describe ________________________
- Will the individual be receiving medications while at camp? (Prescription or OTC) YES NO

(If "YES," please list all medications the individual will take while at camp. A medication order form must be completed for each medicine the individual will receive. Please use one form per medicine.) ________________________

VALIDATION OF EXAMINATION

In my opinion, the above individual may participate in an activecamp program with the noted restrictions.

Licenced Provider Signature __________________________________ Date _______

Address _____________________________ City _________ State/Zip________

Telephone ____________________ FAX/Email _____________________________

In order to ensure the quickest receipt of this document please return to the following address:

BB&N Summer Camp, ***Attn: Summer Camp Director*** *, 80 Gerry's Landing Road, Cambridge, MA 02138*